CHAPTER 9

DENIAL, REDUCTION, SUSPENSION OR TERMINATION OF WAIVER SERVICES

Any time a waiver service is denied, reduced, suspended or terminated, the participant/legal guardian must be given written notice of the action and must be given written notice of the right to request reconsideration/appeal. Additionally, there is a ten (10) calendar day waiting period (from the date form is completed and sent to the participant/legal guardian) before proceeding with a reduction, suspension or termination (See the list of exceptions below).

The following exceptions do not require a ten (10) calendar day notice before proceeding with the action:

- Denial of waiver service(s), including requests for units beyond established limits
- Client-requested reduction
- Termination due to loss of Medicaid eligibility
- Voluntary withdrawal
- Termination due to death
- Termination due to move out of state
- Termination due to admission to an ICF/ID/Nursing Facility or Jail
- Suspension of services due to Hospital Admission

Denials: If the participant/legal guardian requests a waiver service and is denied (either at the local or state level), the Service Coordinator or Early Interventionist must complete the Notice of Denial of Service (ID/RD Form 16-A) within two (2) working days of notification that the service is denied. The denied service(s) must be indicated on the form along with the reason(s) and any supporting comments. The original Notice of Denial of Services (ID/RD Form 16-A) is sent to the participant/legal guardian along with the written reconsideration/appeals process included/attached. A copy of the denial must be placed in the participant's file.

Terminations: If a waiver service will be terminated, the Service Coordinator/Early Interventionist must complete the Notice of Termination of Service (ID/RD Form 16-B). The terminated service(s) must be indicated on the form along with the reason(s) and any supporting comments. The effective date for termination must be at least ten (10) calendar days from the date that the form is completed and sent to the participant/legal guardian (exceptions previously noted apply). This gives the participant/legal guardian ten (10) calendar day notice prior to termination and the opportunity to request reconsideration/appeal the decision. If the participant requests a timely reconsideration/appeal (within 10 calendar days of the termination notification), then the participant may choose to continue to receive the services uninterrupted while awaiting the decision. If a Reconsideration decision is upheld, then the participant may be liable for payment of those services. Although the participant has a total of thirty (30) calendar days to request reconsideration/appeal the decision, the service will be terminated if the reconsideration is not requested within ten (10) calendar days. The original Notice of

Termination of Service (ID/RD Form 16-B) is sent to the provider of the service. A copy, with the appeals process included/attached, is sent to the participant/legal guardian, and another copy must be placed in the participant's file.

Note: If the participant/legal guardian requests reconsideration/appeal within 10 calendar days of the notice and chooses to continue to receive services while awaiting the outcome of the reconsideration/appeal, the Service Coordinator/Early Interventionist must contact the provider of service and ensure that the service continues uninterrupted. This contact must be documented in the participant's record.

Suspensions: When enrolled in the ID/RD Waiver, there may be circumstances when a participant's service(s) may need to be suspended. One example is when a participant is admitted to a hospital. In these instances, all waiver services must be suspended. Many participants and their providers of Residential Habilitation have made arrangements for prescribed drugs and Assistive Technology supplies to be delivered directly to the residence on a regular schedule. These arrangements must cease while the participant is hospitalized.

If a waiver service is suspended, the Service Coordinator/Early Interventionist must complete the Notice of Suspension of Service (ID/RD Form 16-C). The service(s) must be indicated on the form along with the reason(s) and any supporting comments. The suspension date will be at least ten (10) calendar days from the date the form is completed and sent to the participant/legal guardian (exceptions previously noted apply). This gives the participant ten (10) calendar day notice prior to suspension of the service and the opportunity to request reconsideration/appeal. As a reminder, **if the participant has been admitted to a hospital, then ten (10) calendar days notice is not required.** If the participant requests reconsideration/appeals within 10 calendar days of the notification, then the participant/legal guardian may choose to continue to receive the services uninterrupted while awaiting the outcome of the reconsideration/appeal. If, however, the decision is upheld upon reconsideration/appeal, then the participant/legal guardian may be liable for payment of those services. Although the participant has a total of thirty (30) calendar days to request reconsideration of/appeal the decision, the service will be suspended if the reconsideration/appeal is not requested within ten (10) calendar days. The original Notice of Suspension of Service (ID/RD Form 16-C) is sent to the provider of the service. A copy, with the reconsideration/appeals process included/attached, must be sent to the participant/legal guardian, and another copy must be placed in the participant's file.

Once the participant is ready to resume the service(s), the Service Coordinator/Early Interventionist must submit a new authorization form to the designated provider(s).

If the Level of Care certification or the Support Plan exceeds three hundred sixty five (365) days, waiver services must be suspended until a current Level of Care certification or Support Plan is completed, at which time a new authorization form must be completed.

Reminder: A waiver service must be received every 30 days in order for the participant to remain enrolled. If all waiver services are suspended for 30 days (for example: a 30 day hospitalization) then the individual must be disenrolled from the waiver (See chapter 7)

Note: If the participant/legal guardian requests reconsideration/appeals within 10 calendar days of the notice of suspension and chooses to continue to receive services while awaiting the outcome of the reconsideration/appeal, the Service Coordinator/Early Interventionist must contact the provider of service and ensure the service continues uninterrupted. This contact must be documented in the participant record.

Reductions: If a waiver service will be reduced, the Service Coordinator/Early Interventionist must complete the Notice of Reduction of Service (ID/RD Form 16-D). The reduced service(s) must be indicated on the form along with the reason(s) and any supporting comments. The reduction effective date must be at least

ten (10) calendar days from the date that the form is completed and sent to the participant/legal guardian. This gives the participant/legal guardian notice prior to reduction of the service and the opportunity to request reconsideration/appeal the decision. If the participant/legal guardian requests reconsideration or appeals within 10 calendar days of the notice, then the participant may choose to continue to receive the services uninterrupted while awaiting the outcome of the reconsideration/appeal. If, however, the decision is upheld upon reconsideration/appeal, then the participant/legal guardian may be liable for payment of those services. Although the participant/legal guardian has a total of thirty (30) calendar days to request reconsideration/appeal, the service will be reduced if the reconsideration is not requested within ten (10) calendar days. The original Notice of Reduction of Service (ID/RD Form 16-D) is sent to the provider of the service. A copy, with the appeals process included/attached, must be sent to the participant/legal guardian, and another copy must be placed in the participant's file. **The Service Coordinator/Early Interventionist must also complete a new authorization, reflecting the reduced units of service, and send the original to the provider.** Copies of the new authorization must also be sent to the participant/legal guardian and placed in the participant's file.

Note: If the participant/legal guardian requests reconsideration or appeals within 10 calendar days of the notice of reduction and chooses to receive services in the authorized amount while awaiting the outcome of the reconsideration/appeal, the Service Coordinator/Early Interventionist must contact the provider of service and ensure that the service continues uninterrupted. This contact must be documented in the participant record.

If a request for reconsideration/notice of appeal is received by SCDDSN Central Office, the Service Coordinator/Early Interventionist will be promptly notified and instructed on how to proceed.

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

INTELLECTUAL DISABILITY/RELATED DIABILITIES WAIVER

NOTICE OF DENIAL OF SERVICE

To: _____ (Please check one: ☐ Participant ☐ Legal Guardian)

Address: _____

_____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED THAT THE REQUEST FOR THE FOLLOWING SERVICE(S) FOR THE PERSON NAMED ABOVE HAS BEEN DENIED PURSUANT TO 42 C.F.R 440.230 (d). EXPLANATION OF APPEAL RIGHTS IS ATTACHED.

☐ Adult Attendant Care Services
☐ Adult Day Health Care
☐ Adult Day Health Care Nursing
☐ Adult Day Health Care Transportation
☐ Adult Companion Services
☐ Adult Dental Services
☐ Adult Vision Services
☐ Audiology Services
☐ Behavior Support Services
☐ Career Preparation Services
☐ Community Services
☐ Day Activity Services
☐ Environmental Modifications
☐ Nursing Services
☐ Personal Care Services ☐ PCI ☐ PCII
☐ Personal Emergency Response System (PERS)
☐ Prescribed Drugs
☐ Private Vehicle Modifications
☐ Psychological Services
☐ Residential Habilitation
☐ Respite Care
☐ Specialized Medical Equipment, Supplies and Assistive Technology (* listed below)
☐ Employment Services ☐ Support Center

* Assistive Tech: _____

Reason:

☐ Need(s) not justified
☐ Service(s) available through State Plan Medicaid
☐ Exceeds service limits
☐ Other: _____

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____

_____

Phone # _____

_____ _____

Signature of Service Coordinator Date

Original: Participant/legal guardian / Copy: File

ID/RD Form 16-A (Revised 12/12) **APPEALS PROCESS MUST BE ATTACHED**

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
INTELLECTUAL DISABILITY/RELATED DIABILITIES WAIVER
NOTICE OF TERMINATION OF SERVICE

To: _____

Address: _____
_____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE PURSUANT TO 42 C.F.R 440.230 (d). ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF MAY BE BILLED.

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☐ Personal Care Services ☐ PCI ☐ PCII
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ☐ Respite Care
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology
- ☐ Support Center Services

Reason:

- ☐ Change in need; no longer justifies original request
- ☐ No longer meets ICF/ID Level of Care
- ☐ Change in provider availability
- ☐ Entered an ICF/ID
- ☐ Voluntary withdrawal
- ☐ Death (do not send a copy to the family)
- ☐ Medical condition has improved
- ☐ Participant/legal guardian requested
- ☐ Medicaid ineligible
- ☐ Participant moved out of state
- ☐ Facility stay exceeded 30 consecutive days
- ☐ Other (explain in comments below)

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone # _____

_____ _____
Signature of Service Coordinator Date

Original: Provider / Copy: Participant/legal guardian, File

ID/RD Form 16-B (Revised 12/12) **APPEALS PROCESS MUST BE ATTACHED**

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

INTELLECTUAL DISABILITY/RELATED DIABILITIES WAIVER
NOTICE OF SUSPENSION OF SERVICE

To: _____

Address: _____
_____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED TO SUSPEND THE PROVISION OF THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE PURSUANT TO 42 C.F.R 440.230 (d). ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF MAY BE BILLED.

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☐ Personal Care Services ☐ PCI ☐ PCII
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ☐ Respite Care
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology
- ☐ Support Center Services

Reason:

- ☐ Entered hospital/rehab (less than 30 calendar days)
- ☐ Entered nursing facility (less than 30 calendar days)
- ☐ Other: _____
- ☐ Entered ICF/ID
- ☐ Entered Jail

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone # _____

_____ _____
Signature of Service Coordinator Date

Original: Provider / Copy: Participant/legal guardian, File

ID/RD Form 16-C (Revised 12/12) **APPEALS PROCESS MUST BE ATTACHED**

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
INTELLECTUAL DISABILITY/RELATED DIABILITIES WAIVER
NOTICE OF REDUCTION OF SERVICE

To: _____

Address: _____
_____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED THAT THE SERVICE BELOW IS BEING REDUCED FOR THE PERSON NAMED ABOVE PURSUANT TO 42 C.F.R 440.230 (d). THIS REDUCTION IS EFFECTIVE ON DATE .

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☐ Personal Care Services ☐ PCI ☐ PCII
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ☐ Respite Care
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology
- ☐ Support Center Services

Reason:

- ☐ Change in need; no longer justifies original request
- ☐ Participant/legal guardian requested
- ☐ Other: _____
- ☐ Medical condition has improved

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone # _____

_____ _____
Signature of Service Coordinator Date

Original: Provider / Copy: Participant/legal guardian, File

 APPEALS PROCESS MUST BE ATTACHED

SCDDSN RECONSIDERATION AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disability/Related Disabilities (ID/RD) Waiver, the Pervasive Developmental Disorder (PDD), the Community Supports Waiver (CSW) and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision must be sent in writing to:

State Director
SCDDSN
P. O. Box 4706
Columbia, SC 29240

The SCDDSN reconsideration process must be completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the participant, the representative or the person assisting the participant in filing the request. If necessary, staff will assist the participant in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the participant/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the participant/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the participant/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the participant/representative fully completes the above reconsideration process and is dissatisfied with the results, the participant/representative has the right to appeal to the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The participant/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The participant/representative must attach a copy of the written reconsideration notification received from the SCDDSN regarding the specific matter that is the subject of the appeal. In the appeal request, the participant/representative must clearly state with specificity, which issue(s) the participant/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The participant/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.